		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041855

Facility Name: Lexington of Orland Park

Address: 14601 S. John Humphrey Drive (Number) Orland Park (City) 60462 (Zip Code)

County: Cook

Telephone Number: (708) 349-8300 **Fax #** (708) 349-4093

IDPA ID Number: 363923895001

Date of Initial License for Current Owners: 07/08/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL		
	Charitable Corp.		Individual		State		
	Trust		Partnership		County		
IRS Exemption Code			Corporation		Other		
		x	"Sub-S" Corp.				
			Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 8/7/01

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	260	Skilled (SNF)	270	96,370	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	260	TOTALS	270	96,370	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,413	2,164	9,282	32,859	8
9	SNF/PED					9
10	ICF	46,942	6,018	791	53,751	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	68,355	8,182	10,073	86,610	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.87%

D. How many bed-hold days during this year were paid by Public Aid? 242 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/8/96

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 8,179

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	359,641	39,744	19,181	418,566		418,566		418,566			1
2	Food Purchase		345,792		345,792		345,792	(14,727)	331,065			2
3	Housekeeping	314,959	57,447		372,406		372,406		372,406			3
4	Laundry	62,806	31,860		94,666		94,666	(4,721)	89,945			4
5	Heat and Other Utilities			212,722	212,722		212,722	3,770	216,492			5
6	Maintenance	101,687		127,856	229,543		229,543	1,989	231,532			6
7	Other (specify):*											7
8	**TOTAL General Services**	839,093	474,843	359,759	1,673,695		1,673,695	(13,689)	1,660,006			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	3,429,331	289,308	15,152	3,733,791		3,733,791		3,733,791			10
10a	Therapy			802,698	802,698		802,698		802,698			10a
11	Activities	209,973	24,454	3,866	238,293		238,293		238,293			11
12	Social Services	53,189		4,533	57,722		57,722		57,722			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,692,493	313,762	847,249	4,853,504		4,853,504		4,853,504			16
	C. General Administration											
17	Administrative	220,951		469,840	690,791		690,791	(469,840)	220,951			17
18	Directors Fees											18
19	Professional Services			115,092	115,092		115,092	(5,541)	109,551			19
20	Dues, Fees, Subscriptions & Promotions			25,782	25,782		25,782	3,880	29,662			20
21	Clerical & General Office Expenses	498,066	39,212	32,264	569,542		569,542	27,190	596,732			21
22	Employee Benefits & Payroll Taxes			589,769	589,769		589,769	69,651	659,420			22
23	Inservice Training & Education			3,590	3,590		3,590		3,590			23
24	Travel and Seminar			1,682	1,682		1,682	1,971	3,653			24
25	Other Admin. Staff Transportation							11,401	11,401			25
26	Insurance-Prop.Liab.Malpractice			141,242	141,242		141,242	2,807	144,049			26
27	Other (specify):*											27
28	**TOTAL General Administration**	719,017	39,212	1,379,261	2,137,490		2,137,490	(358,481)	1,779,009			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,250,603	827,817	2,586,269	8,664,689		8,664,689	(372,170)	8,292,519			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lexington of Orland Park #0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7**	8	9	10	
	D. Ownership											
30	Depreciation			32,149	32,149		32,149	288,049	320,198			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							580,449	580,449			32
33	Real Estate Taxes							456,247	456,247			33
34	Rent-Facility & Grounds			1,894,101	1,894,101		1,894,101	(1,894,101)				34
35	Rent-Equipment & Vehicles			6,959	6,959		6,959	775	7,734			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,933,209	1,933,209		1,933,209	(568,581)	1,364,628			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		171,983	45,252	217,235		217,235		217,235			39
40	Barber and Beauty Shops			33,826	33,826		33,826		33,826			40
41	Coffee and Gift Shops			1,619	1,619		1,619		1,619			41
42	Provider Participation Fee			144,555	144,555		144,555		144,555			42
43	Other (specify):* **Nonallowable costs**			23,075	23,075		23,075	(23,075)				43
44	**TOTAL Special Cost Centers**		171,983	248,327	420,310		420,310	(23,075)	397,235			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,250,603	999,800	4,767,805	11,018,208		11,018,208	(963,826)	10,054,382			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(118)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(4,721)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(19,797)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,227)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,385)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,683)	43		24
25	Fund Raising, Advertising and Promotional	(5,965)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	1,175	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Schedule A	(17,836)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (65,557)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(898,269)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (898,269)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (963,826)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Lexington of Orland Park

ID# 0041855

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

Lexington Health Care Center of Orland Park, Inc.
Provider #0041855
1/1/01- 12/31/01

Schedule A

Schedule VI. Adjustment Detail
Line 29, Other

Description	Amount	Reference
Nonallowable collections	(10,214)	19
Offset miscellaneous income	(4,298)	21
Deferred maintenance amortization	733	6
Out of period legal fees	(4,057)	19
Total	(17,836)	

See Accountants' Compilation Report

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(118)	0	0	0	0	0	0	0	0	0	0	(118)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(4,721)	0	0	0	0	0	0	0	0	0	0	(4,721)	4
5	Heat and Other Utilities	0	0	3,770	0	0	0	0	0	0	0	0	3,770	5
6	Maintenance	0	0	1,256	0	0	0	0	0	0	0	0	1,256	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,839)	0	5,026	0	0	0	0	0	0	0	0	187	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(469,840)	0	0	0	0	0	0	0	(469,840)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	8,730	0	0	0	0	0	0	0	0	8,730	19
20	Fees, Subscriptions & Promotions	0	0	3,880	0	0	0	0	0	0	0	0	3,880	20
21	Clerical & General Office Expenses	0	6,268	25,220	0	0	0	0	0	0	0	0	31,488	21
22	Employee Benefits & Payroll Taxes	0	0	55,042	0	0	0	0	0	0	0	0	55,042	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,971	0	0	0	0	0	0	0	0	1,971	24
25	Other Admin. Staff Transportation	0	0	11,401	0	0	0	0	0	0	0	0	11,401	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	2,807	0	0	0	0	0	0	0	2,807	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	6,268	106,244	(467,033)	0	0	0	0	0	0	0	(354,521)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,839)	6,268	111,270	(467,033)	0	0	0	0	0	0	0	(354,334)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Lexington of Orland Park** **#** **0041855** **Report Period Beginning:** **01/01/01** **Ending:** **12/31/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	272,583	0	15,466	0	0	0	0	0	0	0	288,049	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19,797)	598,728	0	1,518	0	0	0	0	0	0	0	580,449	32
33	Real Estate Taxes	0	454,101	0	2,146	0	0	0	0	0	0	0	456,247	33
34	Rent-Facility & Grounds	0	(1,894,101)	0	0	0	0	0	0	0	0	0	(1,894,101)	34
35	Rent-Equipment & Vehicles	0	0	0	775	0	0	0	0	0	0	0	775	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(19,797)	(568,689)	0	19,905	0	0	0	0	0	0	0	(568,581)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(23,085)	10	0	0	0	0	0	0	0	0	0	(23,075)	43
44	**TOTAL Special Cost Centers**	(23,085)	10	0	0	0	0	0	0	0	0	0	(23,075)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(47,721)	(562,411)	111,270	(447,128)	0	0	0	0	0	0	0	(945,990)	45

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas	30.00%			Lexington Health Care		
John Samatas	30.00%			Systems of Orland		
Cynthia Thiem	30.00%	See attached Schedule B		Park Ltd. Ptsp.	Orland Park	Real estate ptsp.
Dean Sweitzer	10.00%			Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 1,894,101	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	$	$ (1,894,101)	1
2	V	21	Office supplies expense		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	268	268	2
3	V	30	Depreciation		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	272,583	272,583	3
4	V	32	Interest expense		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	592,376	592,376	4
5	V	32	Amortization of mortgage costs		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	6,352	6,352	5
6	V	33	Property taxes		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	454,101	454,101	6
7	V	21	Administrative expenses		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	6,000	6,000	7
8	V	43	State replacement tax		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	10	10	8
9	V								9
10	V								10
11	V								11
12	V				**The owners of Lexington Health Care Center of Orland Park, Inc. own 100%				12
13	V				of Lexington Health Care Systems of Orland Park Ltd Ptsp.				13
14	Total			$ 1,894,101			$ 1,331,690	$ * (562,411)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Orland Park, Inc.
Provider # 0041855 **Schedule B**
1/1/01 - 12/31/01

VII. Related Parties
Related Nursing Homes

Name of facility	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities - gas & electric	$	Royal Management Corp.	**	$ 3,334	$ 3,334	15
16	V	5	Utilities - water & sewer		Royal Management Corp.	**	436	436	16
17	V	6	Repairs & maintenance		Royal Management Corp.	**	874	874	17
18	V	6	Scavenger & exterminating		Royal Management Corp.	**	366	366	18
19	V	6	Security service		Royal Management Corp.	**	16	16	19
20	V	19	Computer consultant & supplies		Royal Management Corp.	**	6,675	6,675	20
21	V	19	Professional fees		Royal Management Corp.	**	2,055	2,055	21
22	V	20	Advertising - help wanted		Royal Management Corp.	**	3,175	3,175	22
23	V	20	Dues & subscriptions		Royal Management Corp.	**	705	705	23
24	V	21	Bank charges		Royal Management Corp.	**	3,803	3,803	24
25	V	21	Communications		Royal Management Corp.	**	687	687	25
26	V	21	Office supplies & printing		Royal Management Corp.	**	8,203	8,203	26
27	V	21	Postage		Royal Management Corp.	**	3,464	3,464	27
28	V	21	Telephone		Royal Management Corp.	**	9,063	9,063	28
29	V	22	FICA		Royal Management Corp.	**	33,765	33,765	29
30	V	22	FUTA		Royal Management Corp.	**	697	697	30
31	V	22	SUTA		Royal Management Corp.	**	1,319	1,319	31
32	V	22	Insurance - W/C		Royal Management Corp.	**	426	426	32
33	V	22	Insurance - Hospitalization		Royal Management Corp.	**	14,100	14,100	33
34	V	22	401(k) and other emp. benefits		Royal Management Corp.	**	4,735	4,735	34
35	V	24	Travel & seminar		Royal Management Corp.	**	1,971	1,971	35
36	V	25	Auto expense		Royal Management Corp.	**	11,401	11,401	36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Orland Park, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 111,270	$ * 111,270	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance - general	$	Royal Management Corp.	**	$ 2,807	$ 2,807	15
16	V	30	Depreciation - vehicles		Royal Management Corp.	**	4,746	4,746	16
17	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	2,922	2,922	17
18	V	30	Depreciation - equipment		Royal Management Corp.	**	7,798	7,798	18
19	V	32	Interest		Royal Management Corp.	**	1,518	1,518	19
20	V	33	Property taxes		Royal Management Corp.	**	2,146	2,146	20
21	V	35	Equipment rental		Royal Management Corp.	**	775	775	21
22	V	17	Management	469,840	Royal Management Corp.	**		(469,840)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Orland Park, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 469,840			$ 22,712	$ * (447,128)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	30.00%	See Schedule C	6	12.00%	Salary	$ 47,523	L17, C1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	30.00%	See Schedule C	3	6.00%	Salary	20,900	L17, C1	2
3	Cynthia Thiem	Owner/officer	Administrative	30.00%	See Schedule C	3	7.50%	Salary	26,222	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	3	6.00%	Salary	10,707	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	7	14.00%	Salary	14,447	L17, C1	5
6	Dean Sweitzer	Owner*	Administrative	10.00%	102,808	5	10.00%	Salary	13,180	L21, C1	6
7											7
8											8
9											9
10		* Dean Sweitzer is an owner only in Lexington Health Care Center of Orland Park, Inc. He is an employee									10
11		of Royal Management Corp. and provides administrative services to Royal Management Corp. His compensation									11
12		has been allocated to all 10 Lexington facilities and Seneca Nursing Home, Inc. d/b/a Lee Manor Nursing Residence.									12
13								TOTAL	$ 132,979		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Lexington Health Care Center of Orland Park, Inc.
Provider # 0041855 **Schedule C**
1/1/01 - 12/31/01

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Bloomingdale, Inc.	13,615	30,961	17,085	6,975	9,414	78,050
Lexington Health Care Center of Chicago Ridge, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Elmhurst, Inc.	11,728	26,672	14,718	6,009	8,110	67,237
Lexington Health Care Center of LaGrange, Inc.	8,628	19,621	10,827	4,420	5,966	49,462
Lexington Health Care Center of Lake Zurich, Inc.	16,123	36,664	20,230	8,260	11,148	92,425
Lexington Health Care Center of Lombard, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Schaumburg, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Streamwood, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Wheeling, Inc.	17,495	39,783	21,953	8,961	12,097	100,289
Seneca Nursing Home, Inc. d/b/a Lee Manor Nursing Residence	3,608	8,205	4,528	1,849	2,495	20,685
Total	142,125	323,194	178,341	72,810	98,270	814,740

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities - gas & electric	Bed Days	751,703	11	$ 26,007	$	96,370	$ 3,334	1
2	5	Utilities - water & sewer	Bed Days	751,703	11	3,397		96,370	436	2
3	6	Repairs & maintenance	Bed Days	751,703	11	6,818		96,370	874	3
4	6	Scavenger & exterminating	Bed Days	751,703	11	2,851		96,370	366	4
5	6	Security Service	Bed Days	751,703	11	125		96,370	16	5
6	19	Computer consultant & supplies	Bed Days	751,703	11	52,068		96,370	6,675	6
7	19	Professional fees	Bed Days	751,703	11	16,027		96,370	2,055	7
8	20	Advertising - help wanted	Bed Days	751,703	11	24,766		96,370	3,175	8
9	20	Dues & subscriptions	Bed Days	751,703	11	5,496		96,370	705	9
10	21	Bank charges	Bed Days	751,703	11	29,664		96,370	3,803	10
11	21	Communications	Bed Days	751,703	11	5,359		96,370	687	11
12	21	Office supplies & printing	Bed Days	751,703	11	63,988		96,370	8,203	12
13	21	Postage	Bed Days	751,703	11	27,021		96,370	3,464	13
14	21	Telephone	Bed Days	751,703	11	70,716		96,370	9,063	14
15	22	FICA	Bed Days	751,703	11	263,374		96,370	33,765	15
16	22	FUTA	Bed Days	751,703	11	5,433		96,370	697	16
17	22	SUTA	Bed Days	751,703	11	10,292		96,370	1,319	17
18	22	Insurance - W/C	Bed Days	751,703	11	3,319		96,370	426	18
19	22	Insurance - Hospitalization	Bed Days	751,703	11	109,982		96,370	14,100	19
20	22	401(k) and other emp. benefits	Bed Days	751,703	11	36,931		96,370	4,735	20
21	24	Travel & seminar	Bed Days	751,703	11	15,373		96,370	1,971	21
22	25	Auto expense	Bed Days	751,703	11	88,927		96,370	11,401	22
23										23
24										24
25	TOTALS					$ 867,934	$		$ 111,270	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	Insurance - general	Bed Days	751,703	11	$ 21,896	$	96,370	$ 2,807	1
2	30	Depreciation - vehicles	Bed Days	751,703	11	37,022		96,370	4,746	2
3	30	Depreciation - leasehold improv.	Bed Days	751,703	11	22,789		96,370	2,922	3
4	30	Depreciation - equipment	Bed Days	751,703	11	60,826		96,370	7,798	4
5	32	Interest	Bed Days	751,703	11	11,844		96,370	1,518	5
6	33	Property taxes	Bed Days	751,703	11	16,719		96,370	2,146	6
7	35	Equipment rental	Bed Days	751,703	11	6,049		96,370	775	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 177,145	$		$ 22,712	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lexington Financial Services						$	$			$	1
2	L.L.C.	x		Mortgage	Varies	12/29/98	9,000,000	8,572,500	12/1/28	Variable	592,376	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 9,000,000	$ 8,572,500			$ 592,376	9
	B. Non-Facility Related*											
10								Amortization of loan costs			6,352	10
11								Interest income offset			(19,797)	11
12								Allocated from management company			1,518	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (11,927)	14
15	TOTALS (line 9+line14)						$ 9,000,000	$ 8,572,500			$ 580,449	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 457,000	1
Allocated from Management Company		2,146	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2000	$ 441,101	2
3. Under or (over) accrual (line 2 minus line 1).		$ (13,753)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 470,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 456,247	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	421,079	8
1997	243,871	9
1998	386,799	10
1999	434,461	11
2000	441,101	12

2000 taxes:	441,101
Estimated increase (6.5%):	1.065
Estimated 2001 taxes	469,772
Use:	470,000

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Orland Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041855

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	27-10-100-099-0000	Land and building	$ 441,100.92	$ 441,100.92
2.	Royal Management Corp. (Omni Partners)		$	$
3.	06-19-201-018	Land and building	$ 68,214.22	$ 2,146.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 509,315.14	$ 443,246.92

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 104,332 B. General Construction Type: Exterior Brick Frame Block and Pre-cast stee Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	152,460	1995	$ 776,408	1
2					2
3	TOTALS	152,460		$ 776,408	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	250		1996	1996	$ 8,455,949	$	40	$ 211,399	$ 211,399	$ 1,161,537	4
5	10		1998	1998	63,790	1,595	40	1,595		4,784	5
6	10		2001	2001							6
7											7
8											8
	Improvement Type**										
9	Electrical wiring			1996	2,304	58	40	58		298	9
10	Paving			1997	11,589		40	773	773	3,477	10
11	Additional building costs			1996	113,337		40	2,833	2,833	14,165	11
12	Wiring			1998	3,932	393	10	393		1,376	12
13	Additional building costs - 10 bed addition			1999	1,808	45	40	45		136	13
14	Seal/restrip parking lot			1999	3,450	230	15	230		575	14
15	Wiring			1999	1,798	45	40	45		112	15
16	Roof repairs			2000	23,201	1,547	15	1,547		2,320	16
17	Electrical wiring			2000	5,732	164	35	164		246	17
18	Ceiling mount curtain rod hardware			2000	6,952	199	35	199		298	18
19	Automatic door closer/sensors			2000	3,624	242	15	242		362	19
20	Seal and restripe parking lot			2001	2,277	114	10	114		114	20
21	HVAC control			2001	2,548	127	10	127		127	21
22	Infrared curtains for elevator doors			2001	4,500	225	10	225		225	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Allocated from management company	1995	$ 12,878	$	35	$ 399	$ 399	$ 2,387	37
38	Allocated from management company	1996	10,475		35	325	325	1,646	38
39	Allocated from management company	1989	363		31	11	11	163	39
40	Allocated from management company - HVAC	1998	272		35	8	8	33	40
41	Allocated from management company - Offices	1999	684		35	21	21	49	41
42	Allocated from management company - Offices	2000	323		35	10	10	16	42
43	Allocated from management company	1987	66,254		31	2,053	2,053	29,012	43
44	Allocated from management company	1993	34		39	1	1	10	44
45	Allocated from management company	1995	1,495		39	46	46	246	45
46	Allocated from management company	1996	295		39	9	9	45	46
47	Allocated from management company - Sidewalk	1998	629		39	19	19	56	47
48	Allocated from management company - Roof	1998	23		15	1	1	7	48
49	Allocated from management company - Awnings	1999	178		39	6	6	11	49
50	Allocated from management company - Parking lot	1999	385		15	12	12	89	50
51	Allocated from management company - Facade	2001	55		15	2	2	2	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,801,134	$ 4,984		$ 222,912	$ 217,928	$ 1,223,924	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 770,136	$ 28,413	$ 82,391	$ 53,978	5-10 years	$ 388,866	71
72	Current Year Purchases	25,261	2,352	2,352		5-10 years	2,352	72
73	Fully Depreciated Assets							73
74	Allocated from management company	84,234		7,797	7,797		61,200	74
75	TOTALS	$ 879,631	$ 30,765	$ 92,540	$ 61,775		$ 452,418	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Allocated from management company			38,134		4,746	4,746		24,842	79
80	TOTALS			$ 38,134	$	$ 4,746	$ 4,746		$ 24,842	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,495,307	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 35,749	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 320,198	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 284,449	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,701,184	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 7,734 Description: Postage meter: $2,428; Copier: $4,531; Allocated from management company: $775
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	23,969	$	343,812	$	23,969	$ 343,812	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		2,886		48,177		2,886	48,177	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	L10A, C3	hrs		40,837		410,709		40,837	410,709	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	L39, C2	# of prescrpts					171,983		171,983	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): See attached Sch. D						45,252			45,252	13
14	TOTAL			$	67,692	$	847,950	$ 171,983	67,692	$ 1,019,933	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Orland Park, Inc.
Provider #0041855
1/1/01- 12/31/01

Schedule D

XIV. Special Services
Line 13, Other

Service	Cost	Line Reference
Oxygen	8,968	L39, C3
Radiology	11,240	L39, C3
Clinitron beds	21,231	L39, C3
Laboratory	3,313	L39, C3
Dentist	500	L39, C3
Total	45,252	

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Orland Park **#** 0041855 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/01 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 661,375	$ 680,919	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 600,000)	3,687,410	3,687,410	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	64,441	64,441	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	56,936	61,613	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,470,162	$ 4,494,383	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	158,629	158,629	12
13	Land		776,408	13
14	Buildings, at Historical Cost		8,569,286	14
15	Leasehold Improvements, at Historical Cost	125,916	231,848	15
16	Equipment, at Historical Cost	219,615	917,765	16
17	Accumulated Depreciation (book methods)	(85,511)	(1,701,184)	17
18	Deferred Charges		1,099	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized mortgage costs		145,965	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 418,649	$ 9,099,816	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,888,811	$ 13,594,199	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 321,821	$ 321,821	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		27,500	29
30	Accrued Salaries Payable	125,134	125,134	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,916	6,916	31
32	Accrued Real Estate Taxes(Sch.IX-B)		470,000	32
33	Accrued Interest Payable		70,671	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	555,170	99,659	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,009,041	$ 1,121,701	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,545,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,545,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,009,041	$ 9,666,701	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,879,770	$ 3,927,498	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,888,811	$ 13,594,199	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Orland Park, Inc.
Provider # 0041855
1/1/01 - 12/31/01 **Schedule E**

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued rent	455,511	
Accrued management fees	34,615	34,615
Accrued 401 (k) contribution	8,184	8,184
Due to Lexington Financial Services I	3,297	3,297
Due to Republic Construction	785	785
401 (k) withholding	2,285	2,285
Other accrued expenses	50,493	50,493
Total line 36	555,170	99,659

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Miscellaneous Income	4,298
Investment income in Lexington Financial Services, L.L.C.	5,189
Total line 28	9,487

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,907,041	1
2	Restatements (describe):		2
3	**Prior year post closing entries**	(108,889)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,798,152	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,261,618	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,180,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,081,618	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,879,770	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,075,280	1
2	Discounts and Allowances for all Levels	(530,870)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,544,410	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,330,596	6
7	Oxygen	3,626	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,334,222	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	3,272	12
13	Barber and Beauty Care	43,087	13
14	Non-Patient Meals	118	14
15	Telephone, Television and Radio	166	15
16	Rental of Facility Space		16
17	Sale of Drugs	185,428	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,217	19
20	Radiology and X-Ray	11,750	20
21	Other Medical Services	111,151	21
22	Laundry	4,721	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 371,910	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,797	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,797	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule E	9,487	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,487	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,279,826	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,673,695	31
32	Health Care	4,853,504	32
33	General Administration	2,137,490	33
	B. Capital Expense		
34	Ownership	1,933,209	34
	C. Ancillary Expense		
35	Special Cost Centers	275,755	35
36	Provider Participation Fee	144,555	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,018,208	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,261,618	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,261,618	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
This entity files a cash basis tax return.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	918	1,025	$ 38,646	$ 37.70	1
2	Assistant Director of Nursing	3,695	3,834	91,276	23.81	2
3	Registered Nurses	37,616	40,158	910,062	22.66	3
4	Licensed Practical Nurses	38,120	40,267	772,556	19.19	4
5	Nurse Aides & Orderlies	139,545	144,918	1,499,662	10.35	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,024	10,529	117,129	11.12	8
9	Activity Director	4,311	5,089	57,342	11.27	9
10	Activity Assistants	17,073	18,443	152,631	8.28	10
11	Social Service Workers	3,673	3,895	53,189	13.66	11
12	Dietician	133	277	3,970	14.33	12
13	Food Service Supervisor	2,067	2,090	29,508	14.12	13
14	Head Cook	2,722	2,823	27,232	9.65	14
15	Cook Helpers/Assistants	20,460	21,667	184,807	8.53	15
16	Dishwashers	18,120	18,910	114,124	6.04	16
17	Maintenance Workers	7,194	7,700	101,687	13.21	17
18	Housekeepers	45,301	47,749	314,959	6.60	18
19	Laundry	9,828	10,266	62,806	6.12	19
20	Administrator	1,846	2,171	101,152	46.59	20
21	Assistant Administrator					21
22	Other Administrative	883	891	119,799	134.45	22
23	Office Manager					23
24	Clerical	28,682	30,983	498,066	16.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	392,211	413,685	$ 5,250,603 *	$ 12.69	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 19,181	L1,C3	35
36	Medical Director	Monthly	21,000	L9, C3	36
37	Medical Records Consultant	19	925	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,866	L11, C3	44
45	Social Service Consultant	Monthly	4,533	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	19	$ 50,705		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	409	$ 8,177	L10, C3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	409	$ 8,177		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
See attached Schedule F			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 469,840
TOTAL (agree to Schedule V, line 17, col. 3)	$ 469,840
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
American Express Tax & Bus.Svs.	Accounting	$ 7,168
Altschuler, Melvoin & Glasser LLP	Accounting	20,076
Aetna Life Insurance & Annuity	401(k)	450
American Recruiters	Recruiting	17,500
Health Safety Association, Inc.	Consulting	5,453
James Samatas	Legal	102
Personnel Planners	U/C Consulting	1,775
Royal Management	Website Development	611
Sachnoff & Weaver	Legal	38,167
Systematic Management	Billing Consulting	9,059
See attached Schedule F		14,731
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 115,092

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,196
Unemployment Compensation Insurance	52,692
FICA Taxes	402,374
Employee Health Insurance	106,608
Employee Meals	14,609
Illinois Municipal Retirement Fund (IMRF)*	
401(k) contribution	11,198
Other employee benefits	15,743
TOTAL (agree to Schedule V, line 22, col.8)	$ 659,420

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	20,831
Health Care Worker Background Check	
(Indicate # of checks performed 81)	1,239
Miscellaneous licenses, permits & inspec.	3,676
Miscellaneous dues and subscriptions	36
Allocated from management company	3,880
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,662

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,682
Allocated from management company	1,971
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,653

* Attach copy of IMRF notifications

**See instructions.

Lexington Health Care Center of Orland Park, Inc.
Provider # 0041855
1/1/01 - 12/31/01

Schedule F

XIX. Support Schedules

A. Administrative Salaries

Name	Function	Ownership	Amount
Janet Cantelo	Administrator	0%	45,695
Colleen Kamin	Administrator	0%	42,957
Lynn Ryan	Administrator	0%	12,500
John Samatas	Admin/Plant Ops	30%	20,900
James Samatas	Administrative	30%	47,523
Cynthia Thiem	Administrative	30%	26,222
George Samatas	Administrative	0%	10,707
Jason Samatas	Administrative	0%	14,447
	Total		220,951

C. Professional Services

Vendor/Payee		Type	Amount
	AIM	Computer Maintenance	2,570
	Information Controls, Inc.	Computer Maintenance	1,507
	Advanced Answers on Demand	Computer Maintenance	413
	Robert Stachura	Accounting	27
	Freidman, Anselmo & Lindberg	Collections	10,214
			14,731
Total, Agrees to Schedule V, Line 19, Column 3			115,092
Allocated from management co.			
	Altschuler, Melvoin & Glasser, LLP/ American Express Tax & Business Services	Accounting	1,326
	James Samatas	Filing and recording fees	7
	Sachnoff & Weaver	Legal	69
	BDO Seidman, LLP	Accounting	21
	Robert Stachura	Accounting	4
	Pension Administrators	401 (k) Administration	280
	Various	Consulting	346
	Various	Computer Services	6,677
Nonallowable legal fees			
	Freedman, Anselmo, & Lindberg	Legal-collection fees	(10,214)
	Sachnoff & Weaver	Out of period fees	(4,057)
Total, Agrees to Schedule V, Line 19, Column 8			109,551

See accountants' compilation report.

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Painting & decorating	2000	$ 2,198	3	$	$	$ 366	$ 733	$ 733	$ 366	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 2,198		$	$	$ 366	$ 733	$ 733	$ 366	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park **#** 0041855 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **89,802** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **144,555**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **14,609** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **118**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	359,641	39,744	19,181	418,566	0	418,566	0	418,566
2. Food Purchase	0	345,792	0	345,792	0	345,792	-14,727	331,065
3. Housekeeping	314,959	57,447	0	372,406	0	372,406	0	372,406
4. Laundry	62,806	31,860	0	94,666	0	94,666	-4,721	89,945
5. Heat and Other Utilities	0	0	212,722	212,722	0	212,722	3,770	216,492
6. Maintenance	101,687	0	127,856	229,543	0	229,543	1,989	231,532
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	839,093	474,843	359,759	1,673,695	0	1,673,695	-13,689	1,660,006
9. Medical Director	0	0	21,000	21,000	0	21,000	0	21,000
10. Nursing & Medical Records	3,429,331	289,308	15,152	3,733,791	0	3,733,791	0	3,733,791
10a. Therapy	0	0	802,698	802,698	0	802,698	0	802,698
11. Activities	209,973	24,454	3,866	238,293	0	238,293	0	238,293
12. Social Services	53,189	0	4,533	57,722	0	57,722	0	57,722
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	3,692,493	313,762	847,249	4,853,504	0	4,853,504	0	4,853,504
17. Administrative	220,951	0	469,840	690,791	0	690,791	-469,840	220,951
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	115,092	115,092	0	115,092	-5,541	109,551
20. Fees, Subscriptions & Promotion	0	0	25,782	25,782	0	25,782	3,880	29,662
21. Clerical & General Office	498,066	39,212	32,264	569,542	0	569,542	27,190	596,732
22. Employee Benefits & Payroll	0	0	589,769	589,769	0	589,769	69,651	659,420
23. Inservice Training & Education	0	0	3,590	3,590	0	3,590	0	3,590
24. Travel and Seminar	0	0	1,682	1,682	0	1,682	1,971	3,653
25. Other Admin. Staff Trans	0	0	0	0	0	0	11,401	11,401
26. Insurance-Prop.Liab.Malpractice	0	0	141,242	141,242	0	141,242	2,807	144,049
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	719,017	39,212	1,379,261	2,137,490	0	2,137,490	-358,481	1,779,009
29. Total General Administrative	5,250,603	827,817	2,586,269	8,664,689	0	8,664,689	-372,170	8,292,519
30. Depreciation	0	0	32,149	32,149	0	32,149	288,049	320,198
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	580,449	580,449
33. Real Estate	0	0	0	0	0	0	456,247	456,247
34. Rent - Facility & Grounds	0	0	1,894,101	1,894,101	0	1,894,101	########	0
35. Rent - Equipment & Vehicles	0	0	6,959	6,959	0	6,959	775	7,734
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	1,933,209	1,933,209	0	1,933,209	-568,581	1,364,628
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	171,983	45,252	217,235	0	217,235	0	217,235
40. Barber and Beauty Shop	0	0	33,826	33,826	0	33,826	0	33,826
41. Coffee and Gift Shops	0	0	1,619	1,619	0	1,619	0	1,619
42. Provider Participation	0	0	144,555	144,555	0	144,555	0	144,555
43. Other (specify):*	0	0	23,075	23,075	0	23,075	-23,075	0
44. Total Special Cost Ce	0	171,983	248,327	420,310	0	420,310	-23,075	397,235
45. Grand Total	5,250,603	999,800	4,767,805	########	0	########	-963,826	########

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	661,375	680,919
2. Cash - F	0	0
3. Account	3,687,410	3,687,410
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	64,441	64,441
7. Other Pr	0	0
8. Account	56,936	61,613
9. Other (s	0	0
10. Total cı	4,470,162	4,494,383
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	158,629	158,629
13. Land	0	776,408
14. Buildin	0	8,569,286
15. Leaseh	125,916	231,848
16. Equipm	219,615	917,765
17. Accum	-85,511	########
18. Deferre	0	1,099
19. Organi:	0	0
20. Accum	0	0
21. Restric	0	0
22. Other L	0	0
23. other (s	0	145,965
24. Total L	418,649	9,099,816
25. Total A	4,888,811	########
CURRENT LIABILITIES		
26. Accour	321,821	321,821
27. Officer'	0	0
28. Accour	0	0
29. Short-T	0	27,500
30. Accrue	125,134	125,134
31. Accrue	6,916	6,916
32. Accrue	0	470,000
33. Accrue	0	70,671
34. Deferre	0	0
35. Federa	0	0
36. Other C	555,170	99,659
37. Other C	0	0
38. Total C	1,009,041	1,121,701
LONG TERM LIABILITES		
39.Long-Te	0	0
40.Mortgag	0	8,545,000
41.Bonds F	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	0	8,545,000
46.Total Li	1,009,041	9,666,701
47.Total Ec	3,879,770	3,927,498
48.Total Li	4,888,811	########

		Balance per Medicaid Trial Balance
1.	Gross F	12,075,280
2.	Discour	-530,870
	Subtota	11,544,410
4.	Day Ca	0
5.	Other C	0
6.	Therapy	1,330,596
7.	Oxygen	3,626
	Subtota	1,334,222
9.	Paymer	0
10.	Other	0
11.	Nurses	0
12.	Gift an	3,272
13.	Barber	43,087
14.	Non-P	118
15.	Teleph	166
16.	Rental	0
17.	Sale o	185,428
18.	Sale o	0
19.	Labora	12,217
20.	Radiol	11,750
21.	Other	111,151
22.	Laund	4,721
	Subtot	371,910
24.	Contril	0
25.	Interes	19,797
	Subtot	19,797
27.	Other	9,487
28.	Other	0
	Subtot	9,487
30.	Total F	13,279,826
31.	Gener	1,673,695
32.	Health	4,853,504
33.	Gener	2,137,490
34.	Owner	1,933,209
35.	Specia	275,755
35.	Provid	144,555
37.	Other	0
40.	Total E	11,018,208
41.	Incom	2,261,618
42.	Incom	0
43.	Net In	2,261,618

Page

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19 The bottom right side of page under **, you must write in any comments
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RECONCILIATION REPORT **Lexington of Orland Par** **03:15 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-963,826	equal to	-963,826	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	580,449	equal to	580,449	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	456,247	equal to	456,247	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	320,198	equal to	320,198	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	7,734	equal to	7,734	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	802,698	equal to	802,698	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	171,983	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,673,695	equal to	1,673,695	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,853,504	equal to	4,853,504	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	2,137,490	equal to	2,137,490	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,933,209	equal to	1,933,209	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	275,755	equal to	275,755	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	144,555	equal to	144,555	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,312,202	equal to	3,429,331	-117,129	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	209,973	equal to	209,973	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	53,189	equal to	53,189	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	359,641	equal to	359,641	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	101,687	equal to	101,687	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	314,959	equal to	314,959	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	62,806	equal to	62,806	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	220,951	equal to	220,951	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	498,066	equal to	498,066	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	5,250,603	equal to	5,250,603	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	19,181	< or = to	19,181	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	21,000	< or = to	21,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	10,302	< or = to	15,152	-4,850	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	3,866	< or = to	3,866	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	4,533	< or = to	4,533	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.		equal to	220,951	#VALUE!	#VALUE!	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	469,840	equal to	469,840	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	115,092	equal to	115,092	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	659,420	equal to	659,420	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	29,662	equal to	29,662	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	3,653	equal to	3,653	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	144,555	equal to	144,555	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	14,609	< or = to	69,651	-55,042	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	14,609	equal to	14,609	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	8,179	equal to	9,282	-1,103	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-898,269	equal to	-898,269	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	8,572,500	equal to	8,572,500	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	470,000	equal to	470,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	776,408	equal to	776,408	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	8,801,134	equal to	8,801,134	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	917,765	equal to	917,765	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,701,184	equal to	1,701,184	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	3,879,770	equal to	3,879,770	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	2,261,618	equal to	2,261,618	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	1,099	equal to	1,099	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	4,888,811	equal to	4,888,811	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1